JOINT & SPINE
2327 Neva Road
Antigo, WI 54409

CONFIDENTIAL PEDIATRIC HEALTH RECORD

NEW PATIENT ❑
REACTIVATE ❑

PLEASE PRINT: DATE:_____

CHILD'S FULL NAME_____ PARENT'S HOME PHONE_____
MOTHER & FATHER'S NAME_____ PARENT'S WORK PHONE_____
PARENT'S STREET/P.O. ADDRESS_____
CITY/STATE/ZIP_____
CHILD'S BIRTHDATE?_____ CHILD'S S.S.#_____

WHO IS RESPONSIBLE TO PAY FOR SERVICES?	INSURANCE SUBSCRIBER'S INFORMATION
NAME:_____	NAME:_____
ADDRESS:_____	ADDRESS:_____
PHONE:_____	PHONE:_____
S.S.#_____	S.S.#_____
DOB_____	DOB_____
EMPLOYER_____	EMPLOYER_____

WHY DID YOU CHOOSE THIS OFFICE?_____
NAME OF THE PERSON WHO REFERRED YOU:_____

CHIEF COMPLAINT

PLEASE DESCRIBE YOUR CHILD'S PAIN OR CONDITION

FOR WHAT CONDITION ARE YOU CONSULTING THE DOCTOR? _____
_____
_____
WHEN DID IT BEGIN?_____
SINCE THAT TIME, HAS THE PROBLEM BECOME ❑ BETTER ❑ WORSE ❑ STAYED THE SAME?
HOW DID IT OCCUR?_____
DO THE SYMPTOMS CHANGE WITH THE TIME OF DAY? CONSTANT, COMES AND GOES_____
WHAT MAKES THE CONDITION BETTER?_____
WHAT MAKES THE CONDITION WORSE?_____
LIST ANY VISIBLE BUMPS, SCRAPES, CUTS, ETC. ON YOUR CHILD:_____
_____

YES	NO	
❑	❑	HAS THERE BEEN A CHANGE IN YOUR CHILD'S EATING HABITS? IF SO, WHAT?_____
❑	❑	HAS THERE BEEN A CHANGE IN YOUR CHILD'S SLEEPING HABITS? IF SO, WHAT?_____
❑	❑	DOES YOUR CHILD CRY IF A PARENT ATTEMPTS TO CHANGE HIS/HER SLEEPING POSITION?_____
❑	❑	DOES YOUR CHILD WAKE UP AND CRY FREQUENTLY AT NIGHT?_____
❑	❑	ARE THERE ANY OTHER ALTERATIONS OF YOUR CHILD'S NORMAL SLEEP PATTERNS?_____
❑	❑	DOES YOUR CHILD HAVE A FEVER OF UNKNOWN ORIGIN?_____
❑	❑	DOES YOUR CHILD HAVE A LOSS OF APPETITE OR OTHER RECENT EATING DISORDERS?_____
		_____
❑	❑	DOES YOUR CHILD HAVE A RECENT CHANGE IN "BATHROOM" HABITS?_____
❑	❑	HAS YOUR CHILD RECENTLY BECOME IRRITABLE / RESTLESS / GRUMPY, ETC.?_____

PAST MEDICAL HISTORY

YOUR CHILD'S BIRTH:
WAS THE CHILD'S DELIVERY ❑ VAGINAL OR ❑ CESAREAN?_____
WAS THE CHILD BORN ❑ HEAD DOWN ❑ BREECH OR ❑ SHOULDER DOWN?_____
❑ YES ❑ NO WERE EXTRACTION AIDS (FORCEPS/SUCTION) USED DURING DELIVERY? _____

YES	NO	
❑	❑	HAS YOUR CHILD EVER SEEN A CHIROPRACTOR BEFORE? WHEN?_____
		DOCTOR'S NAME AND LOCATION:_____
		FOR WHAT CONDITION?_____
		HOW MANY TIMES HAVE YOU HAD THIS CONDITION BEFORE? ❑ 0-3 TIMES? ❑ 4 OR MORE TIMES?
❑	❑	HAS YOUR CHILD EVER SEEN ANYONE ELSE FOR THIS CONDITION? WHEN?_____
		WHERE TREATED?_____ BY WHOM?_____
		RESULTS:_____ DIAGNOSIS:_____

YES NO

❑ ❑ ALLERGIES? TO WHAT?_____

❑ ❑ DOES YOU CHILD TAKE PRESCRIPTION DRUGS, OVER-THE-COUNTER DRUGS, VITAMINS, OR SUPPLEMENTS?

PRODUCT/DRUG	REASON	FREQUENCY	DOSAGE	HELPING?

❑ ❑ HAS YOUR CHILD EVER BEEN IN AN AUTOMOBILE ACCIDENT?

WHEN?_____ WAS ANYTHING INJURED? ❑ NO ❑ YES, WHAT?_____

HOW WAS IT TREATED?_____

RESULTS OF TREATMENT: (COMPLICATIONS, COMPLETE RECOVERY) _____

❑ YES ❑ NO WAS YOUR CHILD RIDING IN A CHILD SEAT? _____

WAS THE SEAT IN THE ❑ REAR SEAT ❑ FRONT SEAT; FACING ❑ FORWARD OR ❑ BACKWARD?_____

❑ YES ❑ NO WAS YOU CHILD IN A BOOSTER SEAT? _____

❑ YES ❑ NO DOES YOUR CAR HAVE AIR BAGS? _____

WAS YOUR VEHICLE STRUCK FROM THE ❑ REAR ❑ FRONT ❑ LEFT SIDE OR ❑ RIGHT SIDE?_____

❑ ❑ HAS YOUR CHILD EVER HAD ANY MAJOR ILLNESSES, INJURIES, FALLS, HOSPITALIZATIONS OR SURGERIES?

FIRST: WHEN?_____ WHAT WAS INJURED?_____

HOW WAS IT TREATED?_____

RESULTS OF TREATMENT: (COMPLICATIONS, COMPLETE RECOVERY) _____

SECOND: WHEN?_____ WHAT WAS INJURED?_____

HOW WAS IT TREATED?_____

RESULTS OF TREATMENT: (COMPLICATIONS, COMPLETE RECOVERY)_____

❑ ❑ HAS YOUR CHILD HAD X-RAYS? WHEN?_____ WHAT BODY PARTS?_____

FAMILY HEALTH HISTORY

LIST MEDICAL CONDITIONS, IF DECEASED FROM WHAT?

MOTHER:_____

FATHER:_____

SISTERS:_____ HOW MANY _____

BROTHERS:_____ HOW MANY_____

SYSTEM REVIEW QUESTIONS

HAVE YOU HAD ANY PROBLEMS WITH THE FOLLOWING AREAS? (PLEASE MARK Y FOR YES AND N FOR NO IN EACH OF THE FOLLOWING:)

1. ___ EYES
2. ___ EARS, NOSE, MOUTH, THROAT
3. ___ HEART
4. ___ LUNGS/BREATHING
5. ___ INTESTINES
6. ____ URINARY
7. ____ MUSCLES
8. ____ NERVES
9. ____ SKIN
10. ____ PSYCHOLOGICAL
11. ____ INTERNAL ORGANS
12. ____ BLOOD
13. ____ ALLERGIES
14. ____ OTHER_____

PLEASE DESCRIBE:_____

ADDITIONAL CONCERNS/COMMENTS:

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT ALL OF THE ABOVE STATEMENTS ARE TRUE. I HEREBY AUTHORIZE THE DOCTOR TO EXAMINE AND TREAT MY CHILD'S CONDITION AS HE/SHE DEEMS APPROPRIATE THROUGH THE USE OF CHIROPRACTIC HEALTH CARE, AND I GIVE AUTHORITY FOR THESE PROCEDURES TO BE PERFORMED.

PARENT/GUARDIAN/LEGAL REPRESENTATIVE SIGNATURE:_____ DATE:_____

D.C./C.A. SIGNATURE:_____ DATE:_____

Informed Consent

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefor it is necessary to inform the patient of such risks prior to initiating care. While Chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be full informed in consenting to treatment.

Chiropractic offices use trained staff personnel to assist with portions of your consultation, examination, x-rays, physical therapy applications, exercise instruction, etc. Occasionally, when your Chiropractor is unavailable, another qualified Doctor of Chiropractic may treat you.

Specific risk possibilities associated with Chiropractic care :

Stroke — Stroke is the most serious complication of Chiropractic treatment. It is, on rare occasions, due to injury of the vertebral artery caused by a cervical spine adjustment or manipulation, and when occurs, may cause temporary or permanent brain dysfunction. On extremely rare occasions death occurs. Because the vertebral arteries, which supply the brain with blood, are located withing the bones of the cervical spine, cervical treatment poses a small risk. The chances of this occurring are estimated at 1 per 400,000 treatments to 1 to 5.85 million treatments. (CMAJ 2001 Oct. 2; 165 (7):905-6). The annual incidence of a spontaneous stroke is estimated at 1 to 1.5 per 100,000 (NEJM, 1994; 330:339-397). The results of a retrospective study conducted by Haldeman S, Et. Al, suggested that stroke should be considered a random and unpredictable complication of any neck movement including cervical manipulation (J Neurol 2002 Aug: 249(8): 1098-104).

Soreness — Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care. While is is not general dangerous, please advise your Doctor of Chiropractic if you experience soreness or discomfort.

Soft Tissue Injury — Occasionally Chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft tissue injury.

Rib Injury — Manual adjustments to the thoracic spine, in rare cases, May cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns — Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but should be reported to your Doctor of Chiropractic or staff if they occur.

Other Problems — There are occasionally other types of side effects associated with Chiropractic care. While these are rare, they should be reported to your Doctor of Chiropractic promptly.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide the very best care is your goal and if the results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions concerning the above, please ask your Doctor of Chiropractic. When you have full understanding and consent to have care provided, please print your name and sign and date below.

Having carefully read the above , I hereby give my informed consent to have Dr. _____ and /or whomever he /she may designate as his /her assistants to examine , x-ray and administer chiropractic care to my child as he /she deems necessary , in my presence or absence .

Patient's Name Printed

Today's Date

Parent or Guardian Signature for Minor

D.C./C.A. Signature